

MONTANA LEGISLATIVE HISTORY

Chapter 134 19 99

Bill H 1560 S _____ Original bill & history ☒ c

H. Committee on Business & Labor

Hearing Date(s) 1/20 ☒ c

_____ c

_____ c

_____ c

Date Out _____ c

S. Committee on Public Health, Welfare & Safety
Business & Labor

Hearing Date(s) 3/05 ☒ c

_____ c

_____ c

_____ c

Did this bill originate in an interim committee? ☐ Yes ☐ No

Committee _____ Report _____

by Request of State Auditor

LEGISLATIVE HISTORIES SINCE 1997

The scope and depth of legislative committee minutes varies by year and by committee. If you would like additional information about a hearing, you may want to determine whether the hearing was recorded. In addition, some recent floor debates were also recorded. For information on accessing or purchasing these recordings, contact the Historical Society Archives at 406-444-4774.

If you have concerns regarding the format of the enclosed committee minutes or the recordings of the hearings, it is suggested that you contact your state legislators.

HISTORY AND FINAL STATUS 1999

1/29	Referred to Business and Industry		
3/05	Hearing		
3/08	Committee Executive Action--Bill Concurred as Amended	6	0
3/08	Committee Report--Bill Concurred as Amended		
3/10	2nd Reading Concurred as Amended	39	10
3/11	3rd Reading Concurred	42	8
	Returned to House with Amendments		
4/13	2nd Reading Senate Amendments Concurred	99	0
4/14	3rd Reading Passed as Amended by Senate	88	11
4/14	Sent to Enrolling		
4/15	Returned from Enrolling		
4/16	Signed by Speaker		
4/16	Signed by President		
4/16	Transmitted to Governor		
4/20	Signed by Governor		
4/22	Chapter Number Assigned		
	Chapter Number 364		
	Effective Date: 10/01/1999 - All Sections		

HB 156 Introduced by Tropila

LC0360 Drafter: B. Campbell

Require Insurers, Health Service Corporations, and Health Maintenance Organizations That Limit Health Care Service Payments Based on Standards Described as Usual and Customary, Reasonable and Customary, Prevailing Fee, Allowable Charges, a Relative Value Schedule, or Other Comparable Terms to Include in the Policy, Certificate, Membership Contract, or Subscriber Contract an Explanation of How the Charges Are Determined;...

By Request of State Auditor

12/23	Introduced		
1/04	1st Reading		
1/04	Referred to Business and Labor		
1/20	Hearing		
1/21	Committee Executive Action--Bill Passed as Amended	18	0
1/21	Committee Report--Bill Passed as Amended		
1/25	2nd Reading Passed as Amended	96	2
1/27	3rd Reading Passed	96	4
	Transmitted to Senate		
1/28	Referred to Public Health, Welfare and Safety		
3/05	Hearing		
3/06	Committee Executive Action--Bill Concurred	8	0
3/06	Committee Report--Bill Concurred		
3/08	2nd Reading Concurred	50	0
3/09	3rd Reading Concurred	50	0
	Returned to House		
3/09	Sent to Enrolling		
3/10	Returned from Enrolling		
3/13	Signed by Speaker		
3/15	Signed by President		
3/15	Transmitted to Governor		
3/23	Signed by Governor		
3/24	Chapter Number Assigned		
	Chapter Number 134		
	Effective Date: 10/01/1999 - All Sections		

HOUSE BILL NO. 156

INTRODUCED BY TROPILA J

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURERS, HEALTH SERVICE CORPORATIONS AND HEALTH MAINTENANCE ORGANIZATIONS THAT LIMIT HEALTH CARE SERVICE PAYMENTS BASED ON STANDARDS DESCRIBED AS USUAL AND CUSTOMARY, REASONABLE AND CUSTOMARY, PREVAILING FEE, ALLOWABLE CHARGES, A RELATIVE VALUE SCHEDULE, OR OTHER COMPARABLE TERMS TO INCLUDE IN THE POLICY, CERTIFICATE, MEMBERSHIP CONTRACT, OR SUBSCRIBER CONTRACT AN EXPLANATION OF HOW THE CHARGES ARE DETERMINED; AND AMENDING SECTION 33-15-308, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-15-308, MCA, is amended to read:

"33-15-308. Explanation of charges. ~~A disability~~ An insurer, health service corporation, or health maintenance organization that issues policies, certificates, or membership contracts, or subscriber contracts ~~that issues policies, certificates, or contracts for delivery in this state, or that renews, extends or modifies policies, certificates, or contracts on or after October 1, 1995, shall include in the definitions for terms that limit and that limits payment of health services based on standards described as usual and customary, reasonable and customary, prevailing allowable charges, or a relative value schedule, or other comparable terms shall include, displayed in the schedule page of the policy, certificate, membership contract, or subscriber contract:~~

(1) a definition of the term or terms and an explanation of how the limitation of payment is derived;

(2) if the standard of the term or terms is derived by the use of a database, a description of the database reasonably calculated to inform the insured or certificate holder of the method used to calculate the geographic or demographic area from which the data used to determine the term or terms is derived and

(3) These definitions must inform a statement informing the insured that the insured's health

rovider may charge more than the limits established by the defined terms and that ~~such~~ the additional charges may not be covered by the policy, certificate, ~~or~~ membership contract, or subscriber contract."

- END -

MINUTES

**MONTANA HOUSE OF REPRESENTATIVES
56th LEGISLATURE - REGULAR SESSION**

COMMITTEE ON BUSINESS AND LABOR

Call to Order: By **CHAIRMAN BRUCE SIMON**, on January 20, 1999 at
8:00 A.M., in Room 104 Capitol.

ROLL CALL

Members Present:

Rep. Bruce Simon, Chairman (R)
Rep. Bob Pavlovich, Vice Chairman (D)
Rep. Paul Sliter, Vice Chairman (R)
Rep. Joe Barnett (R)
Rep. Rod Bitney (R)
Rep. Sylvia Bookout-Reinicke (R)
Rep. Roy Brown (R)
Rep. David Ewer (D)
Rep. Carol C. Juneau (D)
Rep. Billie Krenzler (D)
Rep. Bob Lawson (R)
Rep. Gay Ann Masolo (R)
Rep. Gary Matthews (D)
Rep. Joe McKenney (R)
Rep. Carolyn Squires (D)
Rep. Jay Stovall (R)
Rep. Cliff Trexler (R)
Rep. Carley Tuss (D)

Members Excused: None.

Members Absent: None.

Staff Present: Stephen Maly, Legislative Branch
Pati O'Reilly, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: SB 4 (1/14/99) HB 121, HB 154,
HB 156, HB 181, 1/8/1999
Executive Action: SB 4, HB 154, HB 156

Mike Oliver, Enoco Glass

{Tape : 1; Side : B; Approx. Time Counter : 150 - 158}

Opponents' Testimony: None

Questions from Committee Members and Responses:

Reps. Lawson, Barnett, Bookout, Simon, Pavlovich, and Simon question proponents.

{Tape : 1; Side : B; Approx. Time Counter : 158 - 408}

Closing by Sponsor: Rep. Gallus closed HB 154.

{Tape : 1; Side : B; Approx. Time Counter : 408 - 500}

HEARING ON HB 156

Opening Statement by Sponsor: Rep. Tropila, HD 47 introduced HB 156. EXHIBIT(7)

{Tape : 2; Side : A; Approx. Time Counter : 0 - 22}

Proponents' Testimony:

Frank Cote, Deputy Insurance Commissioner, State Auditor's Office.

{Tape : 2; Side : A; Approx. Time Counter : 22 - 67}

Diane Clark, Butte, MT EXHIBIT(8)

{Tape : 2; Side : A; Approx. Time Counter : 67 - 188}

Larry Dryer, Helena banker

{Tape : 2; Side : A; Approx. Time Counter : 188 - 399}

Chuck Butler, Blue Cross and Blue Shield of Montana

{Tape : 2; Side : A; Approx. Time Counter : 399 - 481}

Don Allen, Montana Medical Benefits Plan

{Tape : 2; Side : A; Approx. Time Counter : 481 - 500}

Ray Gustafson,

{Tape : 2; Side : B; Approx. Time Counter : 0 - 19}

Craig Sweet, Montana Public Interest Group

{Tape : 2; Side : B; Approx. Time Counter : 19 - 45}

Kip Smith, Montana Primary Care Assn.

{Tape : 2; Side : B; Approx. Time Counter : 45 - 70}

Irene Theurer, AARP

{Tape : 2; Side : B; Approx. Time Counter : 70 - 77}

Al Pontrelli, Montana Assn. of Underwriters

{Tape : 2; Side : B; Approx. Time Counter : 77 - 82}

Mike Costell, Bozeman, MT

{Tape : 2; Side : B; Approx. Time Counter : 82 - 104}

Opponents' Testimony: None

Questions from Committee Members and Responses:

Reps. Ewer, Pavlovich, Stovall, Bitney and Simon question proponents and sponsor.

{Tape : 2; Side : B; Approx. Time Counter : 104 - 368}

Closing by Sponsor: Rep. Tropila closed HB 156.

{Tape : 2; Side : B; Approx. Time Counter : 368 - 393}

HEARING ON HB 181

Opening Statement by Sponsor: Rep. Sliter, HD 76 introduced HB 181. EXHIBIT(9) EXHIBIT(10)

{Tape : 2; Side : B; Approx. Time Counter : 393 - 408}

Proponents' Testimony:

Frank Cote, Deputy Insurance Commissioner, State Auditor's Office.

{Tape : 2; Side : B; Approx. Time Counter : 408 - 500}

Jack Driggs, MCRS. Montana Consumers Repair Service.

{Tape : 3; Side : A; Approx. Time Counter : 0 - 30}

Craig Sweet, Legislative Director Montana PRG.

{Tape : 3; Side : A; Approx. Time Counter : 30 - 49}

Rick Booth, Missoula, MT

{Tape : 3; Side : A; Approx. Time Counter : 49 - 78}

Matt McDonald, Billings auto shop

{Tape : 3; Side : A; Approx. Time Counter : 78 - 150}

Donna Fastena, Hank's Body Shop EXHIBIT(11) EXHIBIT(12)
EXHIBIT(13)

{Tape : 3; Side : A; Approx. Time Counter : 150 - 179}

House Bill 156

Requires Insurance Companies to Disclose Potential Costs Beyond Deductibles and Co-payments.

- * This legislation will ensure consumers are informed about the scope of the insurance company's responsibilities in covering the cost of medical services before the services are rendered.
- * HB 156 addresses the single most common consumer complaint about insurance. Consumers are unaware that insurance policies do not pay 100% of the billed amount.
- * Consumers are unaware that policy limits are not the end of their financial exposure. The bill requires that insurance policies spell out what the potential for additional out-of-pocket expenses will be, beyond the deductible and co-pay. NOTE: The legislation simply requires insurers to inform consumers, and does NOT impose restrictions on how or how much an insurer can charge.
- * Examples of actual cases where consumers were expected to pay more than deductible and co-pay.

Procedure	Charge	Allowed Amount	Balance for Consumer
Knee Surgery	\$ 4,736.70	\$ 3,861.00	\$ 875.70
Neurosurgery	\$ 13,466.00	\$ 6,518.15	\$ 6,927.85
Neurosurgery	\$ 27,764.23	\$ 18,777.48	\$ 8,986.75

Requires disclosure on how an insurance company limits payments by a contract provision called UCR (Usual, Customary, and Reasonable). UCR is a term used to limit reimbursement of medical expenses under an insurance policy. UCR is derived through national databases.

JANUARY 20, 1999

EXHIBIT 8
DATE 1/20/99
HB 156

RE: HOUSE BILL #156

MR. CHAIRMAN, LADIES AND GENTLEMEN:

GOOD MORNING; MY NAME IS DIANA CLARK, I RESIDE AT 2411 HARVARD AVE., BUTTE, MT, AND I AM HERE AS A PROPONENT OF HOUSE BILL #156.

IN AUGUST OF 1995, I ENLISTED THE HELP OF THE MONTANA INSURANCE COMMISSION HERE IN HELENA TO HELP ME WITH WHAT WAS AN OVERWHELMING AND SURPRISING STATE OF AFFAIRS.

IT SEEMED SOMEWHERE ALONG THE LINE OF MY AFFILIATION WITH THE JOHN ALDEN LIFE INSURANCE COMPANY, THEY SLIPPED A LOT OF NEW RULES IN TO OUR RELATIONSHIP, HOWEVER, THEY NEGLECTED TO TELL ME. I'M NOT ONE TO LET THINGS SLIDE AND SO I WROTE FOR EXPLANATION AND DEFINITION OF THE NEW RULES.

I RECEIVED NEW DEFINITIONS SUCH AS:

a) INDIVIDUAL CALENDAR YEAR DEDUCTION HAS BEEN MET.

DEFINITIONS DEDUCTIBLE/CALENDAR YEAR DEDUCTIBLE : The amount of covered medical charges you pay each calendar year (January 1 - December 31), before your regular plan benefits begin.

I asked what do you mean before your regular plan benefits begin. What does this mean. I finally figured it out; it was a new way of getting out of paying benefits. I had purchased insurance with a \$1,250.00 deductible, and with this new rule, I purchased a \$1,500.00 deductible without even knowing. This I feel is not usual, customary or reasonable.

b) COVERED CHARGES ARE PAID AT 100% AFTER EITHER YOUR INDIVIDUAL OR YOUR FAMILY OUT-OF-POCKET MAXIMUM HAS BEEN MET.

INDIVIDUAL OUT-OF-POCKET LIMIT: THE MAXIMUM AMOUNT COVERED MEDICAL CHARGES YOU PAY IN A CALENDAR YEAR. AFTER YOUR OUT-OF-POCKET LIMIT AMOUNT IS MET, BENEFITS FOR COVERED CHARGES ARE PAID AT 100% FOR THAT CALENDAR YEAR.

After your out-of-pocket limit amount is met, benefits for covered charges are paid at 100% for that calendar year, meant to me that my medical insurance would pay expenses as per our co-pay agreement, which was at that time 80/20 totaling 100%.

However, that was not the case, the rules again changed as the game was played. My next surprise was that and I quote "Your maximum supplemental diagnostic x-ray/laboratory (DXL) benefit of \$100 has been met. Additional covered charges for these services are subject to regular plan benefits". That was the first time I ever knew that I had a maximum supplemental diagnostic x-ray/laboratory benefit. Diagnosis of illness or injury requires more than a \$100.00 maximum benefit. This I feel is unusual, not customary, and totally unreasonable.

c) THE AMOUNT CHARGED EXCEEDS THE PREVAILING RATE FOR THIS GEOGRAPHIC AREA BY \$218.00. PLEASE CONTACT YOUR HEALTH CARE PROVIDER REGARDING THIS AMOUNT. MANY PROVIDERS, WHEN ASKED BY THEIR PATIENTS, WILL REDUCE THEIR CHARGE TO THE PREVAILING RATE.

THIS AMOUNT CHARGED EXCEEDS THE PREVAILING RATE FOR THIS GEOGRAPHIC AREA BY \$218.00 COULD NOT BE EXPLAINED BY THEIR COMPANY IN A MANNER SUITABLE FOR MYSELF. THIS LED TO MY INCORPORATING THE HELP OF THE COMMISSION AND A LONG FOUGHT BATTLE WITH THE INSURANCE COMPANY'S LEGAL DEPARTMENT.

In the company's explanation of benefits, on claim #951871083499101-

03, attached herewith, the Prevailing Rate Reduction on the following Laboratory procedures was 71% on 86039 Pathology, it was 21% on 86665 Pathology, it was 20% on 82390 Pathology, it was 37% on 86298 Pathology, it was 20% on 86592, it was 25% on 86701, and 42% on 86317, all Pathology, totaling \$218.00 of a \$795.00 bill. I questioned why the differences in the percentages, and so did Mr. John Holbrook of the Insurance Commission.

The answer came as follows: "As long as our prevailing rate falls above the 50th percentile we are in compliance with our certificate of insurance. When we establish prevailing at the 80th percentile it is our choice not a contractual obligation. John Alden is contractually obligated to pay above the 50th percentile, -how much is based on what we determine to be appropriate for the area and the procedure in question." To me this was not usual, customary, or reasonable, it was a clear matter of the insurance company's ability to change the rules as we go along, and I want you to take that ability away.

This was all necessary laboratory work. As far as the geographic area, I wondered how far I would have to travel to have my insurance company pay for the benefits I had purchased. Their definition was: "The country is segmented in different geographic areas for analysis. This segmentation, generally broken down by three digit US zip codes, is done on the basis of fee similarity and geographic location. Whereas we do not define what a geographic area is or how a geographic area is to be determined, we are not obligated to use a specific data base for for Billings only or Butte only, but rather one that includes the Billings and/or Butte area." This garble was not a satisfactory explanation. Mr. Holbrook asked again for them to produce the information we asked for in order to determine the validity of their calculations. ONE YEAR LATER, THEY FINALLY PAID THE CLAIM. Again the rules were changed as we went along. This to me is not usual,

4.

IT IS IMPORTANT TO ME THAT THIS LEGISLATION IS PASSED, IT WOULD BE A GOOD START IN THE CAMPAIGN TO STOP THIS FRAUDULENT PRACTICE. CONSUMERS ARE UNAWARE THAT INSURANCE POLICIES DO NOT PAY 100% OF THE BILLED AMOUNT, NOR HAVE MOST EVER HEARD OF UCR (USUAL, CUSTOMARY, AND REASONABLE).

MY PERSISTENCE IN REQUIRING DISCLOSURE BY MY INSURANCE COMPANY MUST HAVE RATTLED A FEW CAGES, AS SOON, I FOUND MYSELF UNABLE TO PAY THE EXORBITANT PREMIUMS THAT HAD RAISED FROM \$251.15, 80/20 PERCENTILE, JUNE 1, 1994, TO \$602.16, JUNE 30, 1998, 50/50 PERCENTILE TOGETHER WITH ALL THE LIMITED REIMBURSEMENTS WHICH LIE HIDDEN WITHIN THE POLICY.

IT ALSO SEEMED QUITE SUSPECT AND NOT COINCIDENTAL THAT THE 1996 CALENDAR YEAR DEDUCTIBLE RAISED FROM \$250.00 TO \$500.00, AND THE 1996 INDIVIDUAL OUT-OF-POCKET LIMIT RAISED FROM \$1,250.00 TO \$1,500.00, ONE MONTH AFTER MY INQUIRY. AND, AGAIN THE 1997 CALENDAR YEAR DEDUCTIBLE RAISED FROM \$500.00 TO \$750.00 AND THE 1997 INDIVIDUAL OUT-OF-POCKET LIMIT RAISED FROM \$1,500.00 TO \$1,750.00, THE FOLLOWING AUGUST, AGAIN THE ANNIVERSARY OF MY INQUIRY. I DON'T KNOW HOW MUCH THE 1998 AMOUNTS RAISED AS I AM WITHOUT INSURANCE BECAUSE OF THIS MATTER, I JUST COULDN'T PLAY THE GAME ANY LONGER.

NOT ONLY AM I UNABLE TO PAY SUCH HIGH PREMIUMS OF \$602.16 PER MONTH, TOTALING \$7,225.92 YEARLY, THE 1997 CALENDAR YEAR DEDUCTIBLE OF \$750.00, AND THE 1997 INDIVIDUAL OUT-OF-POCKET LIMIT OF \$1,750.00, TOTALING \$9,725.92, PLUS CARRY A



JOHN ALDEN
LIFE INSURANCE COMPANY

EXPLANATION OF BENEFITS

P.O. Box 1599
Boise, ID 83701

August 15 1995

Please see reverse side of this form for definitions and further information.

If you have questions, please call John Alden Life Insurance Company at (800) 328-4316.

Patient	Diana F Clark	Acct #	CLARK.DIA	Group #	752841-000000001-S00
Claim #	951871083499101-03	Insured	William H Clark 2411 Harvard Butte MT 59701	Provider	Anthony M Konecny Md 3215 Ottawa St Butte, MT 59701
Benefits Paid To	Anthony M /Konecny Md	\$	577.00	Issued On	08/15/95.

Description of Service	Service Date	Amount Charged	Prevailing Rate Reduction	Amount Paid	Notes
85651 Pathology	06/13/95	20.00	0.00	20.00	abc
86317 Pathology	06/13/95	55.00	23.00	32.00	abcd
86812 Pathology	06/13/95	70.00	0.00	70.00	abc
86701 Pathology	06/13/95	55.00	14.00	41.00	abcd
82785 Pathology	06/13/95	60.00	0.00	60.00	abc
86592 Pathology	06/13/95	20.00	4.00	16.00	abcd
86298 Pathology	06/13/95	65.00	24.00	41.00	abcd
82390 Pathology	06/13/95	50.00	10.00	40.00	abcd
80019 Pathology	06/13/95	60.00	0.00	60.00	abc
80092 Pathology	06/13/95	65.00	0.00	65.00	abc
86665 Pathology	06/13/95	90.00	19.00	71.00	abcd
86039 Pathology	06/13/95	175.00	124.00	51.00	abcd
36415 Physician	06/13/95	10.00	0.00	10.00	ab
Totals		795.00	218.00	577.00	

71%

This is BS.

P.O. Box 1599
Boise, ID 83701

WILLIAM H CLARK
2411 HARVARD
BUTTE, MT 59701

Please check on this
for me. THANKS
DIANA F. Clark

50/50 PERCENTILE CO-PAYMENT; I AM UNWILLING TO PAY FOR UNDISCLOSED CHARGES ADDED ON. THIS IS NOT REASONABLE BY ANY MEANS, IT SHOULD NOT BE USUAL AND IT SHOULD NOT BE CUSTOMARY.

THANK YOU VERY MUCH FOR YOUR TIME TO HEAR MY MESSAGE. PEOPLE NEED TO BE AWARE OF THE POTENTIAL COSTS AND THE RISKS OF PREVAILING FEES WHEN PURCHASING AN INSURANCE POLICY. IT IS NOW TIME FOR YOU TO TAKE CARE OF THE PEOPLE, NOT THE INSURANCE COMPANIES.

SINCERELY,

A handwritten signature in cursive script that reads "Diana F. Clark". The signature is fluid and elegant, with the first name "Diana" being the most prominent part of the script.

DIANA F. CLARK

MINUTES

**MONTANA SENATE
56th LEGISLATURE - REGULAR SESSION**

COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By **CHAIRMAN AL BISHOP**, on March 5, 1999 at 3:00 P.M., in Room 410 Capitol.

ROLL CALL

Members Present:

Sen. Al Bishop, Chairman (R)
Sen. Fred Thomas, Vice Chairman (R)
Sen. Sue Bartlett (D)
Sen. Dale Berry (R)
Sen. John C. Bohlinger (R)
Sen. Chris Christiaens (D)
Sen. Bob DePratu (R)
Sen. Dorothy Eck (D)
Sen. Eve Franklin (D)
Sen. Duane Grimes (R)
Sen. Don Hargrove (R)

Members Excused: None.

Members Absent: None.

Staff Present: Susan Fox, Legislative Branch
Martha McGee, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: HB 156, HB 190, HJR 22, HB 70,
HB 583, 2/20/1999
Executive Action: HJR 22, HB 190, HB 156, HB 70

VICE CHAIRMAN FRED THOMAS chaired the meeting until **CHAIRMAN AL BISHOP** arrived.

HEARING ON HB 156

Sponsor: REP. JOE TROPILA, HD 47, Great Falls

Proponents: Claudia Clifford, State Auditor's Office
Todd Thun, Montana Nurses' Association
Larry Dreyer, Private Citizen
Bill Olson, AARP
Chuck Butler, Blue Cross/Blue Shield
Don Allen, Montana Medical Benefit Plan

Opponents: None

Opening Statement by Sponsor:

REP. JOE TROPILA, HD 47, Great Falls, said the bill was the result of a compromise, and its purpose was to state, in laymen's language, an explanation of all benefits and their prices on the benefits page of the insurance policy. This would make it easier for people to make a good decision in purchasing insurance.

Proponents' Testimony:

Claudia Clifford, State Auditor's Office, used EXHIBIT(1) for her testimony.

Todd Thun, Montana Nurses' Association (MNA), said they stood in strong support of HB 156.

{Tape : 1; Side : A; Approx. Time Counter : 3.5}

Larry Dreyer, Private Citizen, said in January, 1997, he was diagnosed with an uncommon, though not extremely rare, medical condition. His Blue Cross/Blue Shield (BC/BS) HMO, Primary Care physician told him he wanted to schedule an appointment with a specialist to see if brain surgery was advisable. The charge for the comprehensive consultation was \$209.70; however, BC/BS paid only \$165, which meant he paid about 23%, instead of the usual 20%, of the bill. When he got home, he read his policy, and the fine print said if a non-participating provider was not used, there would be a 10% differential.

He said BC/BS had been his insurer for most of the past 26 years, and throughout that time, his family and he had been referred by

family doctors to many different specialists; however, until the just-mentioned experience, they had never been referred to a non-participating provider. He said he expected to pay his deductibles and co-payments, and was comforted because he thought when he ran into a large bill, the huge costs would be covered. He suggested when patients were referred to a non-participating doctor, they should be informed by their gatekeeper physician their liability could exceed the maximum liabilities in the member contracts.

He reported both he and his wife took time off work in order to keep the appointment with the specialist. Upon discovering he was a non-participant, they told him he would have to cancel the appointment on a moment's notice, if they chose to avoid the possibility of paying more than the insurance company allowed. He maintained consumer protection was warranted at the time of first referral and there was a financial incentive to refer to non-participating providers. If the policy holder accepted his gatekeeper's referral to a non-participating provider, BC/BS automatically saved at least 10% of the allowable fee.

On Saturday, prior to the Monday surgery, he received a letter from BC/BS which acknowledged the need for in-patient care, and about a month later, he realized it contained a "fine-print" warning to "check with your treating physician before obtaining treatment to see whether all members of your physician team are participating providers with Blue Cross. Please be aware there may be...who are not participating providers with BC/BS, even though the hospital is." His bill totaled \$9,300, but BC/BS paid only \$3,436; in other words, he paid about 63% of the bill. The next thing he got was another letter from BC/BS which said the usual physician charges were not necessarily reasonable charges. His complaints against BC/BS included: (1) They refused to pay a reasonable share of his surgery, even though he was not told he was referred to a non-participating physician; (2) Their written warning about using non-participating providers was received by him two days before the scheduled surgery; (3) No forewarning by BC/BS that the group of neurosurgeons had been a previous source of trouble for the insurance company. He said later, BC/BS informed him they made the decision to not pay any amount to resolve the "very large gap" between the provider charges and allowable amount. He was advised he needed an advocate, so he "signed on" with one; however, he later discovered that advocate actually worked for a subsidiary of BC/BS. He said he took it

upon himself to check with neurosurgeons in neighboring states regarding their fees, and discovered his surgeon's fee was just a bit below the average. He reported he began communicating with the State Auditor's Office and they sent a copy of a letter from BC/BS which said it was important for the subscribers to understand how the allowances were calculated. The charges were calculated on comparisons with the federally-established Resource-Based Relative Value System (RBRVS). In other words, BC/BS could pay any amount they felt like paying. Or to put it another way, it meant if they followed the recommendation of their primary care provider, they could be uninsured for the lion's share of the physician's charges.

{Tape : 1; Side : A; Approx. Time Counter : 12.6}

Bill Olson, AARP, said they rose in support of **HB 156**, and the reference to laymen's terms should be cherished.

Chuck Butler, Blue Cross/Blue Shield, said he apologized once again to **Larry Dreyer** for his experience with BC/BS. The record would show that in 1997, BC/BS supported this legislation; however, the problem was they could not come to an agreement with the insurance department. He regretted **Mr. Dreyer** had to come to both the House and this Committee to discuss his personal problems. He expressed full support the bill; in fact, he suggested the Committee pass it today.

Don Allen, Montana Medical Benefit Plan, said they felt it was important the information, as in the bill, be disclosed. They liked the January 1, 2000, amendment because all the policies would be changed over at the same time. They supported the legislation.

Opponents' Testimony: None.

Questions from Committee Members and Responses:

SEN. SUE BARTLETT asked how this bill was different from that in 1997. **Claudia Clifford** said the 1997 legislation attempted to establish standardized systems to be used by each company; however, it was a very difficult thing to do, because companies used a variety of ways to address the issue. They decided it

would be better if both the consumers and the Department were fully informed.

Closing by Sponsor:

REP. JOE TROPILA said the bill was needed on a national, as well as local, level. In laymen's terms, for example, the medical bill is \$100, the deductible has been paid and there is an 80-20 co-payment. It would seem the insurance company would pay \$80.00 and the insured \$20.00; however, they may only allow \$50. That would mean the company would pay 80% of the \$50, and the insured would pay the rest.

{Tape : 1; Side : A; Approx. Time Counter : 18.7}

HEARING ON HB 190

Sponsor: REP. LOREN SOFT, HD 12, Billings

Proponents: Becky Fleming-Siebenaler, Department of Public
Health & Human Services

Susan Held, Montana Child Care Association

Opponents: None

Opening Statement by Sponsor:

REP. LOREN SOFT, HD 12, Billings, said the bill would allow the Department of Public Health & Human Services (DPHHS), to issue three-year licenses to certain day care providers who met the necessary licensing requirements, and who did not have any deficiencies. The reasons for this included DPHHS had about 2,000 licenses to issue every year, and it was almost impossible for the Department to visit the sites on an annual basis. The bill was a result of many agencies working together, and allowed DPHHS to take a proactive, rather than reactive process in working with the people. He stressed if DPHHS got a complaint about a provider, it would immediately examine the complaint. The bill was coaching for success, rather than policing for failure.